

1 **BEFORE THE ARIZONA MEDICAL BOARD**

2 In the Matter of

3 **MICHAEL R. ROLLINS, M.D.**

4 Holder of License No. **30379**
5 For the Practice of Allopathic Medicine
6 In the State of Arizona.

Board Case No. MD-06-0456A

**FINDINGS OF FACT,
CONCLUSIONS OF LAW AND ORDER**

(Letter of Reprimand)

7 The Arizona Medical Board ("Board") considered this matter at its public meeting on
8 October 11, 2007. Michael R. Rollins, M.D. ("Respondent") appeared before the Board with legal
9 counsel Stephen Myers for a formal interview pursuant to the authority vested in the Board by
10 A.R.S. § 32-1451(H). The Board voted to issue the following Findings of Fact, Conclusions of Law
11 and Order after due consideration of the facts and law applicable to this matter.

12 **FINDINGS OF FACT**

13 1. The Board is the duly constituted authority for the regulation and control of the
14 practice of allopathic medicine in the State of Arizona.

15 2. Respondent is the holder of License No. 30379 for the practice of allopathic
16 medicine in the State of Arizona.

17 3. The Board initiated case number MD-06-0456A after receiving notification from a
18 local hospital that Respondent resigned from staff while under investigation. Several of
19 Respondent's cases were reviewed by Board Staff and one, involving a thirty-five year-old male
20 patient ("JH"), was forwarded to the Board for consideration.

21 4. On June 23, 2005 Respondent performed a sigmoid colectomy on JH for recurrent
22 diverticulitis. Respondent inspected the completed anastomosis with a rigid sigmoidoscope and
23 no leak was identified after insufflation of the rectum with the anastomosis underwater. On June
24 26, 2005 JH's hematocrit was 23 and on the next day it dropped to 20. Postoperatively JH's
25 hemoglobin declined from 15.9 on the date of surgery to 7.1 on June 27, 2005. Respondent

1 believed the blood loss was at most a "trickle" and transfused JH with two units of packed cells
2 and the hemoglobin rose to 9.1 on June 28, 2005. JH was discharged on June 29 with a
3 hematocrit of 26. On July 3, 2005, ten days post-surgery, JH collapsed at home and was brought
4 to the emergency room complaining of 10 out of 10 pain and two hours of diffuse abdominal pain
5 with distention and vomiting. The emergency room physician described JH's abdomen as
6 distended and diffusely tender with mild guarding and rebound. Abdominal films demonstrated
7 free air with no definite obstruction or fluid levels. A CT scan of the abdomen demonstrated
8 ascites with free air. The emergency room physician noted JH was stable and well appearing
9 despite his tachycardia. However, the emergency room physician did not believe JH required
10 urgent surgery, but did believe he needed close monitoring.

11 5. Respondent presented to the emergency room and examined JH. Respondent
12 noted a white blood cell count as 7 and a hematocrit of 40. Respondent's impression indicated JH
13 was ten days to two weeks following sigmoidectomy with acute onset of severe abdominal pain
14 with relatively unremarkable CT and laboratory data. Respondent noted the acites were
15 consistent with the postoperative bleeding and the small amount of free air was unremarkable
16 given JH's postoperative status. Respondent planned to follow JH's abdominal examination
17 closely. Nursing notes from July 3 indicate JH's pain level raised between six and ten, most often
18 either nine or ten. The notes also indicate JH was passing blood per rectum and had coffee
19 ground emesis. Respondent was notified of the blood per rectum and an elevated potassium of
20 6.8.

21 6. Respondent was not surprised by the free air and free fluid felt the small amount of
22 free air was left over from his previous surgery and the free fluid was whole blood from JH's post-
23 operative bleed. Respondent discussed the situation extensively with JH and relayed both
24 operative and non-operative approaches to the problem. Respondent and JH chose to pursue the
25 non-operative conservative approach first and Respondent believed this to be a very reasonable

1 option. When it became clear to Respondent the morning of July 4, 2005 that the non-operative
2 approach was failing he told JH he would need to re-explore him. JH did not want another
3 operation.

4 7. In the afternoon of July 4, 2005 Respondent took JH to surgery and performed an
5 exploratory laparotomy with drainage of intra-abdominal abscess, creation of colostomy and
6 placement of central venous line. When the abdomen was opened, Respondent suctioned 3,000
7 ccs of fluid (clotted blood) in the midst of which JH became bradycardic and required CPR lasting
8 approximately six to seven minutes and, after several rounds of medication, JH recovered his
9 own rhythm. Respondent then completed the exploration, discovered a 0.5 centimeter leak in the
10 anterior portion of the anastomosis, divided the sigmoid colon distal to the tear and performed an
11 end colostomy. JH did poorly post-operatively, developing renal failure and requiring
12 hemodialysis. JH was returned to the operating room four times for "washout of his abdomen"
13 and ultimately to close the abdominal wall. JH remained essentially unresponsive even following
14 weaning from sedation on July 20, 2005. JH's clinical status was consistent with global anoxic
15 injury and this was confirmed by MRI. JH remained in a persistent vegetative state. JH underwent
16 tracheostomy on August 4, 2005 and was transferred to a skilled nursing facility where he died on
17 August 6, 2005. Respondent did not expect such a rapid decline in an otherwise relatively
18 healthy, yet obese, young man and was very sorry for the outcome. Respondent believes in
19 retrospect that JH's cardiac arrest was due to hypovolemia.

20 8. In order for JH's hematocrit to drop from 47 to 20 after the first surgery he would
21 have had to lose about five liters of blood in a seventy-two to ninety-six hour period. Re-
22 exploration at this point did not guarantee Respondent would have found the source of the bleed,
23 but he could have looked for the source. Had Respondent re-explored he may have been able to
24 correct the source of the bleeding and evacuate, prior to JH's discharge, what turned out to be a
25 very large pelvic hematoma.

9. The standard of care required Respondent to recognize and timely diagnose and treat a post-operative complication of hemorrhage.

10. Respondent deviated from the standard of care by failing to recognize and timely diagnose and treat JH's post-operative complication of hemorrhage.

11. JH died.

CONCLUSIONS OF LAW

1. The Arizona Medical Board possesses jurisdiction over the subject matter hereof and over Respondent.

2. The Board has received substantial evidence supporting the Findings of Fact described above and said findings constitute unprofessional conduct or other grounds for the Board to take disciplinary action.

3. The conduct and circumstances described above constitutes unprofessional conduct pursuant to A.R.S. § 32-1401(27)(q) (“[a]ny conduct or practice that is or might be harmful or dangerous to the health of the patient of the public”) and A.R.S. § 32-1401(27)(II) (“[c]onduct that the board determines is gross negligence, repeated negligence or negligence resulting in harm to or the death of a patient.”).

ORDER

Based upon the foregoing Findings of Fact and Conclusions of Law,

IT IS HEREBY ORDERED:

Respondent is issued a Letter of Reprimand for failure to timely operate on a patient with post-operative complications.

RIGHT TO PETITION FOR REHEARING OR REVIEW

Respondent is hereby notified that he has the right to petition for a rehearing or review. The petition for rehearing or review must be filed with the Board's Executive Director within thirty (30) days after service of this Order. A.R.S. § 41-1092.09(B). The petition for rehearing or review

1 must set forth legally sufficient reasons for granting a rehearing or review. A.A.C. R4-16-103.
2 Service of this order is effective five (5) days after date of mailing. A.R.S. § 41-1092.09(C). If a
3 petition for rehearing or review is not filed, the Board's Order becomes effective thirty-five (35)
4 days after it is mailed to Respondent.

5 Respondent is further notified that the filing of a motion for rehearing or review is required
6 to preserve any rights of appeal to the Superior Court.

7 DATED this 11TH day of MARCH, 2008.



THE ARIZONA MEDICAL BOARD

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10
11 By *L. S. Wynn*
12 Lisa S. Wynn
Executive Director

13 ORIGINAL of the foregoing filed this
14 11th day of March 2008 with:

15 Arizona Medical Board
16 9545 East Doubletree Ranch Road
17 Scottsdale, Arizona 85258

18 Executed copy of the foregoing
19 mailed by U.S. Mail this
20 11th day of March 2008, to:

21 Stephen Myers
22 Myers & Jenkins, PC
23 3003 North Central Avenue – Suite 1900
24 Phoenix, Arizona 85012-2910

25 Michael R. Rollins, M.D.
Address of Record
David B. Bump